A Report on Colorado's Behavioral Health Peer Provider Workforce

Current Status and Recommendations for Workforce Development

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The Peer and Family Workgroup, a subcommittee of the Behavioral Health Transformation Council (BHTC) has been keeping this movement towards standardization for peers alive since 2011. Below is a list of the workgroup members (as of September 2014):

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Our apologies for anyone who was inadvertently excluded from this list.

EXECUTIVE SUMMARY

The main goal of this document is to outline the evolving peer workforce and a suggested direction for workforce development in Colorado. It includes:

- A description and brief history of the different behavioral health peer professions in Colorado as they currently exist,
- The progress that has been made in establishing a cohesive workforce,
- A summary of state and national findings and examples of best practices,
- And suggestions for moving forward with development of the peer workforce.

Peers helping peers, individuals who have experienced a similar condition or circumstance, supporting and mentoring others; this type of mutual understanding and support occurs in a vast array of situations from cancer survivors to recovering alcoholics. The peer behavioral health workforce is made up of three distinct groups:

- Peer Supporter Specialists – individuals who are in recovery from a mental illness.
- Recovery Coaches – individuals who are in recovery from addiction.
- Family Systems Navigators and Family Advocates – individuals who are the parent or family member of someone affected by a behavioral health issue.

Peer supporters have been providing services in Colorado since at least 1986. Specific duties and job titles have changed, but the core of peer support, that those who have faced similar issues can use their shared experiences to provide a unique service to others, has remained the same.

In 2011, the Peer and Family Workgroup was created as a subcommittee of the Behavioral Health Transformation Council (BHTC). Their task was to bring together stakeholders from the peer support workforce to help guide the state in determining the best strategic direction. The Peer and Family Workgroup revised the core competencies for the peer provider profession and a plan for credentialing in Colorado.

In 2014, five convenings were held around the state to bring together stakeholders interested in advancing the profession of peer support. Issues of great concern to participants were legitimizing the profession through credentialing, addressing the stigma within community mental health centers, and providing support to peer professionals.

The Substance Use and Mental Health Services Administration (SAMHSA) recognizes peer support as a best practice. Peer support has proven its effectiveness in many different research studies. Reduction in hospitalization and increased recovery for individuals working with peer support specialists has been documented.

Some of the important steps in supporting the peer workforce are credentialing for peers and training for supervisors. Training for supervisors and others is needed to increase the understanding of the unique role of peers. Credentialing is probably the single most important step in growing and supporting a qualified peer workforce in Colorado. Without credentialing it will be difficult for the peer profession to gain legitimacy and recognition.

SECTION ONE

In Colorado there are hundreds of individuals out in the community working and volunteering their time to help others navigate our behavioral health (mental health and substance abuse) care system. These individuals are people who have themselves been diagnosed with a mental illness, suffered with addiction or been the parent or family member of an individual who has been affected by a behavioral health condition. This "quasi-profession" is made up of three distinct groups of providers; peer specialists, recovery coaches and family systems navigators and/or family advocates. In an attempt to clarify the important role of each of these groups, the following document has been compiled by a subgroup of the Behavioral Health Transformation Council's Continuum of Care Committee, the Peer and Family Workgroup.

To simplify we will use the term "Peer Support Provider" to refer to all three of these groups collectively. Below we define each of the three peer professions, explain the various roles they each fulfill and describe the rules/statutes (or lack thereof) involved in making their roles legitimate. It is the belief of the advocacy groups involved that, "Peer support is based on the belief that people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations"[1].

Definitions of Peer Support Providers in Colorado

Peer Support Specialist

Other names: Peer Specialist, Peer Advocate, Peer Navigator, Wellness Advocate, Recovery Specialist

Definition: Peer Specialist definitions in Colorado vary greatly depending on the program and job duties; most include a statement of the peer using his/her own recovery experience as a means of inspiring hope in others and providing mentorship. Below is the Substance Abuse and Mental Health Services Administration (SAMHSA) definition for a peer specialist:

Peer Recovery Support Coaching is a set of non-clinical, peer-based activities that engage, educate and support an individual successfully to make life changes necessary to recovery from disabling mental illness and/or substance use disorder conditions. The activities that comprise this service are education and coaching. A key element contributing to the value of this service is that Peer Recovery Support Coaches appropriately highlight their personal experience of lived experience of recovery[2].

Summary of Job Duties: Case management (navigate healthcare, appointments, find resources, drive to appointments, emotional support, follow-up after appointments), group facilitation, community outreach, curriculum development, teaching skills/WRAP, running drop-in centers, and assisting with transition planning (from inpatient to community).

[1] Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin 32 (3)*

[2] Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

Recovery Coach

Definition:
A Recovery Coach is a;

- Motivator and cheerleader (exhibits bold faith in individual/family capacity for change; encourages and celebrates achievement)
- Ally and confidant (genuinely cares, listens and can be trusted with confidences)
- Truth-teller (provides a consistent source of honest feedback regarding self-destructive patterns of thinking, feeling and acting)
- Role model and mentor (offers his/her life as living proof of the transformative power of recovery; provides stage-appropriate recovery education and advice)
- Problem solver (identifies and helps resolve personal and environmental obstacles to recovery)
- Resource broker (links individuals/families to formal and indigenous sources of sober housing, recovery-conducive employment, health and social services, and recovery support)
- Advocate (helps individuals and families navigate the service system assuring service access, service responsiveness and protection of rights)
- Community organizer (helps develop and expand available recovery support resources)
- Lifestyle consultant (assists individuals/families to develop sobriety-based rituals of daily living), and
- A friend (provides companionship)[3].

Family Systems Navigator and Family Advocate
Other names: Family Navigator, Parent Advocate, Family Associate, Parent Support Partner, Family Peers, Certified Parent Support Providers

Definition:

According to the Colorado revised statutes (27-69-102) a "Family Advocate" means a parent or primary caregiver who:

a) Has been trained in a system of care approach to assist families in accessing and receiving services and supports;
b) Has raised or cared for a child or adolescent with a mental health or co-occurring disorder; and
c) Has worked with multiple agencies and providers, such as mental health, physical health, substance abuse, juvenile justice, developmental disabilities, education, and other state and local service systems.

"Family Systems Navigator" is an individual who:

a) Has been trained in a system of care approach to assist families in accessing and receiving services and supports;
b) Has the skills, experience, and knowledge to work with children and youth with mental health or co-occurring disorders; and
c) Has worked with multiple agencies and providers, such as mental health, physical health, substance abuse, juvenile justice, developmental disabilities, education, and other state and local service systems.

[3] Advocates for Recovery Website: http://advocatesforrecovery.org/what-we-do/

SECTION TWO

The Origins of Peer Support Specialists in Colorado

In the Spring of 1986 the Colorado Division of Mental Health (now called the Office of Behavioral Health) and the Regional Assessment and Training Center (RATC, a local non-profit) piloted a program to train and employ individuals with chronic mental illness to provide case management services to others receiving mental health services at four community mental health centers in Denver. The participants were called Case Manager Aides (CMAs) and shared ten full-time jobs. At the end of the two-year follow-up, 15 of the original 25 trainees were still employed as Case Manager Aides. Working with the Colorado Division of Vocational Rehabilitation and the Community College of Denver, the program offered a multi-week competency-based training, college credit, internships, and support for the program graduates[4].

The Regional Assessment and Training Center (RATC) Case Manager Aide program operated across the Denver Metro area and elsewhere in the country and offered annual trainings up until 2003 (when RATC was closed due to funding cuts). For a couple of years in the late 1990s, RATC also operated a Peer Support Warm Line funded by local mental health centers. Many Peers working in the mental health system today received their original training in the RATC CMA program.

Nate Rockitter, MA, started another metro area peer training program in 1993. Through his experience in mental health and supervising counselors working with adolescents, Nate developed a manual (Person to Person) to train people with mental health issues in order to help their peers in a counselor role. The training is based on skill building, relationship building and the group process.

Nate began instructing groups in 1993 and although participants were learning skills and utilizing the material in their lives, the question, in terms of seeking meaningful employment, "What can I do with this?" was frequently asked. The question was answered in 1996 when the Community Connections drop-in center (sponsored by Behavioral Healthcare, Inc.) employed four peer specialists (two at the drop-in center and two at Aurora Mental Health's residential programs). The program expanded to three peer specialist teams (approximately 4-6 part time peer specialists per team) in Adams and Arapahoe County. The supervisors were Peer specialists who advanced in the organization. Other qualified participants in the training were obtaining employment at Behavioral Healthcare, Inc. (BHI), as managers and staff of drop-in centers and empowerment programs.

From 1999-2004, YAPS (Young Adult Peer specialists) was instituted to train peer specialists 18-24 years of age to work with youth. Four YAPS were hired by BHI to work in a youth outreach program at Community Connections and youth day treatment programs at Arapahoe/Douglas Mental Health Center and Community Reach Center. One graduate of the program is a state advocate for youth today.

Nate Rockitter continued to provide training in Colorado and throughout the United States. In 2000, the training manual, Person to Person, was revised to become Training the Trainer and from 2006- 2013 the training was offered as part of the Community College of Denver's Human Services Certificate Program. During that time agencies in the Denver Metro area were utilizing the training for their peer specialists to improve their skills and Behavioral Healthcare, Inc. was

[4] Sherman, PS and Porter, R: Mental Health Consumers as Case Manager Aides, *Hospital and Community Psychiatry,* 42:484-497, (1991).

employing qualified graduates. In 2011, Training the Trainer was translated into Spanish (La Formaciỏn Del Formador) and was utilized to train Behavioral Health Promoters in Dona Ana County, New Mexico in 2012. The Peer Specialist Program is still in existence today.

In 1998, Dr. Ed Knight, ValueOptions' Vice President for Recovery, began providing trainings to centers and organizations affiliated or in partnership with ValueOptions. Dr. Knight continued providing trainings until 2010 when Clarence Jordan, ValueOptions new Vice President for Recovery, began offering the trainings.

The statewide peer-run organization, Colorado Mental Wellness Network, formerly known as WE CAN! Of Colorado, began offering peer trainings in 2012. This training met the Colorado Combined Core Competencies and offered an alternative to behavioral health provider trainings for those not part of the publicly funded system. Five classes totaling 40+ individuals have graduated since its inception, with a 98% success rate of employment following completion. Various mental health centers and behavioral health organizations have also developed ad hoc peer trainings over the years to meet their needs when a more established training was not available.

The Origins of Family Systems Navigators and Family Advocates in Colorado

The Federation of Families for Children's Mental Health (FFCMH) is a state chapter of the National Federation for Children's Mental Health. FFCMH is a family-driven and family-run non-profit organization that provides the "family voice" in Colorado's behavioral health care system. The group was incorporated as a non-profit organization 501(c)(3) in 1993. The Federation helps families of children with mental health and co-occurring substance use issues maneuver through the complicated behavioral health care system in Colorado by providing education, support, advocacy, and promotion of mental health needs of children and families. FFCMH believes that families are the experts on their children and that the family voice is vital in policymaking. FFCMH is committed to constantly modifying, changing and creating new ways to better serve, support and empower families. This family organization provides family advocacy services for families seeking services for their child as well as state wide trainings, technical assistance and policy consultation.

In 2007, the Colorado General Assembly passed House Bill (H.B.) 07-1057, establishing the creation of family advocacy demonstration programs for juveniles with mental health or co-occurring disorders who are in or at–risk of becoming involved with the juvenile justice system (as outlined in Section One). An additional piece of legislation was introduced in 2011and continued many of the elements of HB1057. FFCMH supported HB11-1193, concerning integrated system of care family advocacy programs for mental health juvenile justice populations, again bringing family members to testify about the effectiveness of family advocacy. This bill continued the definitions of family advocates and family systems navigators and tasked the Office of Behavioral Health (OBH) with writing the rules and standards.

A toolkit was compiled by the Federation of Families for Children's Mental Health - Colorado Chapter in collaboration with Tracy Kraft-Tharp and the Juvenile Justice/Mental Health Subcommittee. Additionally, family members, juvenile justice, education and other human service professionals provided input on the content of the Toolkit. The toolkit can be found on FFCMH's website. In 2012, the Federation was able to bring a training program for family advocates to Colorado. Funding for this training came from the Colorado Juvenile Justice and Delinquency Prevention Council and the Colorado Department of Human Services' Division of Behavioral Health Supplemental Block Grant. Tennessee Voices supplied the curriculum and

FFCMH trained 10 people to be trainers. Currently, there are 35 trained family advocates throughout the state in addition to the 10 who were trained initially.

SECTION THREE

Colorado's Core Competencies

In 2008, the state Office of Member/Consumer Family Affairs directors (OMFA/OCFA) got together in response to the 2007 CMS letter to State Medicaid Directors. Their concern was that in order for a state to use Medicaid funds to reimburse peer specialists, the peer specialists had to meet several criteria. One of the requirements was to be trained or certified in a state approved program. At that time, the state did not have an approved training or certification program. Since the behavioral health organizations were employing peers, the OMFA/OCFA directors felt it was imperative to have something in place that would help the state meet this requirement. They met over the course of several months, and developed the first set of core competencies for peer specialists in Colorado.

The Advocates Forum, a group of community stakeholders, facilitated by Deborah Amesbury, an independent contractor, reviewed and approved the competencies before they were submitted to the state. In 2012 the Peer and Family Workgroup, a subcommittee of the Behavioral Health Transformation Council (BHTC), a Governor-appointed council reporting to the Governor's cabinet, revised the core competencies. The workgroup combined the core competencies from the three distinct peer provider areas in the state; family system navigators and family advocates, recovery coaches and peer support specialists. In 2013 the group finalized the combined core competencies and took them to the BHTC for approval, they were also submitted to Health Care Policy and Financing (HCPF) for adoption. All peers in Colorado must be trained to meet these core competencies.

See the revised competencies below:

Knowledge of Mental Health/Substance Use Conditions and Treatments - Recognize signs and coping strategies, including the grief process - Know when to refer to a clinician - Know when to report to a supervisor - Understand interactions of physical and behavioral health
Clients Rights/Confidentiality/Ethics/Roles - Understand scope of duties and role - Understand HIPAA / protected health information / confidentiality - Maintain professional boundaries - Recognize potential risks - Advocate when appropriate
Interpersonal Skills - Communication - Diversity and cultural competency - Relationship development - Use guiding principles pertinent to population served - Model appropriate use of personal story and self-advocacy - Goal-setting, problem-solving, teamwork, & conflict resolution

Resiliency, Recovery and Wellness - Understand principles and concepts of resiliency, recovery, and a wellness oriented lifestyle - Assist others with their own resiliency and recovery - Encourage options and choices - Understand impacts of labels, stigma, discrimination, and bullying - Understand person-centered resiliency and recovery planning for all ages and stages - Promote shared decision-making
Resources - Knowledge of community resources and those specific to behavioral health and physical Health and how to navigate the benefits system - Help individuals and families recognize their natural supports ***** Knowledge of public education and special education system and other child-serving systems
Self-care - Recognize when health may compromise the ability to work - Acknowledge that personal wellness is a primary responsibility - Set boundaries between work and personal life
Teaching Skills - Demonstrate wellness and teach life skills - Encourage the development of natural supports - Assist people to find and use psycho-education materials
Basic Work Competencies - Seek supervision and/or ask for direction - Accept feedback - Demonstrate conflict resolutions skills - Navigate complex work environments
Trauma-Informed Support - Understand impact of trauma and responses to trauma - Demonstrate sensitivity and acceptance of individual experiences - Practice cultural sensitivity - Promote shared decision-making

* Item pertains specifically to Family Advocates / Family Systems Navigators
For a list of resources and sources of input for the creation of this document see the appendix.

Authored by the Peer and Family Workgroup, a sub-committee of the Colorado Behavioral Health Transformation Council. Co-Chairs (at the time of publication): Tonya Wheeler, Advocates for Recovery, Tom Dillingham, Federation of Families for Children's Mental Health and Amanda Kearney-Smith, Colorado Mental Wellness Network.

SECTION FOUR

Overview of the Statewide Peer Workforce Initiative Convenings

With generous funding from the Colorado Trust and support from former program officer Laurel Petralia, the Colorado Mental Wellness Network (CMWN) conducted a series of discussion groups, called "convenings", around the state during the first part of 2014. Each of these convenings was designed to solicit information and recommendations on the current peer support workforce and how the state should proceed expanding and enhancing the field.

Convenings were held in the following locations in Colorado on the dates indicated:

- Northern Colorado: Greeley on February 20, 2014
- Southern Colorado: Pueblo on February 26, 2014
- Metro Area (inclusive of Colorado Springs): Denver on April 16, 2014 (two convenings were held, a morning and afternoon session)
- Western Colorado: Montrose on May 5, 2014

The overall question presented to each group was: *How do we move the peer support specialist workforce forward in Colorado?*

Each convening included presentations on the background and history of peer support work in Colorado, and innovative peer support specialist (PSS) programs and practices around the world. This was followed by small group discussions on what is moving peer work forward and what is holding it back. Remarks about what was going well currently in Colorado were consistent across the different convenings. These included:

- Strong commitment, motivation, and dedication of most PSS who are working and volunteering.
- Enthusiasm of people receiving peer support.
- The fact that peer support is now an evidenced based practice (EBP).
- Clinicians seeing the benefits for clients working with PSS.
- Some clinicians regularly referring people to work with the PSS.
- Relatively low cost and high impact.
- The observation that peer support specialists provide a unique service which creates hope for clients.

Something going well specifically for the Greeley area is that Value Options (the managed care organization or behavioral health organization) pays for training and that is a big help to both PSS and provider organizations.

The barriers to advancing peer support specialist work identified during the first activity included:

- Lack of funding for both training and hiring PSS.
- Lack of legitimacy and respect from professionals.
- Lack of standards [for training and the profession as a whole].
- Unavailability of training for both the primary PSS training and ongoing training for skill enhancement.
- Lack of understanding about peer work and the effectiveness.
- Peer support specialists feel overworked – not enough PSS for the need.
- Training and resources are centralized in Denver and limits access in other parts of the state.
- Low pay for PSS, but also a concern that pay will result in a loss of benefits.
- Not everyone is meant to be a PSS – several peer support specialists voiced the concern that some individuals are encourage to get training but are not really appropriate and this creates stigma.

Common Themes

The idea that funding and training are lacking was expressed clearly across all convening events. Also, consistent with the different regional groups was the idea of a perceived lack of legitimacy. The perception is that some providers (clinicians/physicians) and others within the behavioral healthcare community (e.g., administrative staff, leadership) do not understand what peer support specialists do and don't always see the value of the work.

The lack of legitimacy and confusion about PSS roles are tied together. Peer support specialists noted that in many locations the clinical staff doesn't know who they are or what they do.

Some PSS do not feel supported in some locations. They feel overworked and underpaid and there are few resources for additional training to improve their skills.

In Greeley, Pueblo, and Montrose, participants felt that resources and efforts are concentrated in Denver and it is more challenging for them to move programs forward.

Low wages and no way to advance were also identified by many PSS as barriers. However there is an alternate side to this issue. Some PSS were concerned that working at too high of a salary could decrease their benefits. This puts PSS in a difficult situation when accepting a job and walking away from needed benefits. Rather than an either-or situation of full or part time work, a range of job opportunities was suggested.

A topic that came up in two convenings was that some individuals had been trained as PSS who either weren't ready or possibly would never be ready for this kind of work. The PSS felt that this reflects poorly on all other PSS and hinders the work to legitimize peer services. Some felt there has been a tendency for organizations to look at PSS training as a kind of recovery training and refer anyone for training whether or not they would make a good PSS.

During the first group presentations on successes and barriers, key topics were identified for more in depth discussion. Convening participants then voted on what they most wanted to talk about and broke into small groups to discuss.

Topics were very often inter-related, as one would expect, so there was some overlap in discussions. In some locations, groups combined topics that were similar (topics included; credentialing, stigma, awareness, advancement opportunities, role clarification, etc.).

For each discussion topic groups were asked to identify:

- Why the topic was important.
- The challenges related to this topic.
- Their vision for this topic.
- Steps to achieve the vision.

Highlights from Small Group Discussions

Standardization and Credentialing

The most common phrases that came up around this topic were credibility, legitimacy, and confidence. Participants thought that the clarification of roles and standardization of the training process would bring respect and recognition for PSS and could also provide more confidence to the PSS. It would mean more acceptance on the part of clinicians, less stigma, and hopefully more pay. A standardized process also would screen out individuals who are not appropriate as PSS.

There was a general consensus that some kind of standardization needed to take place but there were different ideas about what that might look like. Participants also used the terms credentialing, accrediting, licensing, and standardizing interchangeably, but sometimes meaning different things.

All groups agreed that whatever the credentialing process it must be affordable to potential peer support specialists and organizations.

Steps Identified to Move toward a Credentialing Process

- Set a timeline for establishing a credentialing process.
- Don't re-invent the wheel; research what other states have done to be successful.
- Office of Behavioral Health should prioritize this.
- Set the criteria for both training and the path for legitimacy.
- Do a better job of making programs aware of the state combined competencies.
- Ensure that the process is culturally competent.
- Create a similar language around peer support for the entire health care system.
- Involve stakeholders in all parts of the process.
- Deliver training in all parts of the state.
- Create a system for continuing education credits.
- Create specialized curriculum for focusing on work with specific groups (i.e., seniors, those in criminal justice system, etc.).

Creating More Awareness of Peer Support Specialist Work

This topic is important for the same reason that standardizing the process is important, it legitimizes the work. When staff, individuals receiving services (clients), and family members do not understand what peer support can offer, there is confusion and a devaluing of the work.

The challenges related to this topic are some of the same challenges to simply hiring PSS. The service is not prioritized and so funding is not available. Lack of transportation in rural areas also limits the ability of PSS to see people, although this is a problem with all services in rural areas. Many individuals living in rural communities do not have internet so even emailing with a PSS is impossible.

Steps for Creating More Awareness of Peer Support Specialist Work:

- Better communication and education within the employing organization so that all employees understand what PSS do and can begin referring people.
- As a part of orientation, make sure new PSS are introduced to other key staff.
- Have written materials that explain what PSS work is for staff, clients, and other key stakeholders.
- Include PSS on teams and invite to trainings so they are truly part of the workforce.
- Have PSS speak at staff meetings and trainings.
- Have peer support specialists present at community events (i.e., health fairs) to explain the benefits of the service.

Stigma

There is still much stigma around having a mental health diagnosis in the workplace and in general. Clinicians may have strong opinions about the ability of someone with a diagnosis to be able to work. PSS do not feel they are always taken seriously and feel they must prove themselves over and over. There needs to be more understanding of the role and benefits. The credentialing process could help to reduce stigma by clearly establishing training requirements and roles.

Challenges of stigma go beyond the mental health community and include the negative portrayal in the media and lack of cultural awareness. Self-stigma limits peer support specialists in their ability to advocate for a client they may be working with. They may censor themselves or feel they aren't able to speak up for this person.

Steps to Reduce Stigma within the Workplace for Peer support specialists

- Make sure the PSS are part of the team.
- Have a policy in place that includes peer support specialists in office-wide trainings and staff meetings.
- Tell the stories of recovery and peer support work on a regular basis.
- Share the research on the efficacy of PSS.
- Make sure that roles and expectations are clear on all sides.
- Work to raise community awareness of mental health issues.

Summary of Group Discussion Ideas

As already noted, many of the small group discussions hit on common themes:

- The value of peer support specialist work.
- A need to establish legitimacy and clear definitions for what PSS do through credentialing or some other process.
- A need for organizations to do more to include and promote PSS within their own organizations.
- A need for funding to help with training and hiring PSS.
- Unified leadership to move this process forward.
- The importance of promoting PSS work, talking about the success stories and the research.

Lastly, there was much excitement at all convenings about the work of peer support specialists and the accomplishments that have happened up to this point. The convenings themselves were seen as positive events where people came to learn, share, and be a part of moving the system forward.

SECTION FIVE

The Power of Peer Support: Why Peer Support Works

In this section we will be discussing the effectiveness of peer supporters and recovery coaches. For this to be fully understood, it is necessary to understand the difference. Recovery coaches are people who volunteer their services and are generally not looking for full time employment, whereas peer specialists are employed, mostly on a part-time basis but more and more are seeking full-time employment.

To date, there is no standardization of training programs [nationally], but despite the lack of coherence across states' programs, there are many skills that are included in all programs such as, listening, showing empathy, sharing experiences, inspiring or enhancing motivation, setting recovery goals, linking people to resources and services, teaching, giving feedback, setting boundaries, encouraging, praising, relapse planning, collaborating with colleagues, and others[5].

The Center for Medicaid Services (CMS) in its 2007 letter to States indicates that, "Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of

[5] Equipping Behavioral Health Systems & Authorities to Promote Peer Specialist/Peer Recovery Coaching Services, 2012

mental health and substance use services, can be an important component in a State's delivery of effective treatment"[6].

In 2006 the Georgia Department of Behavioral Health & Developmental Disabilities compared consumers using certified peer specialists as a part of their treatment versus consumers who received the normal services in day treatment (the control group). Consumers were randomly assigned to each group. Consumers using the services of certified peer specialists showed improvement as compared to the control group in each of three outcome areas over an average of 260 days between assessments: Reduction of current symptoms/behaviors, increase in skills/abilities, ability to access resources/and meet their own needs[7].

In comparing the costs of services, clients receiving services from certified peer specialists cost the state on average, $997.00, per year, versus the average cost of $6,491.00 in day treatment. That's an average savings of $5,494.00 per person for the state[8].

Reduction of Hospitalization

Peer support specialists are being used in a variety of setting throughout the country. One program run by the New York Association of Psychiatric Rehabilitation Services (NYAPRS) was evaluated by Cheryl MacNeil, Ph.D., who identified and examined several areas where the project benefited those involved, "The most substantial finding is that the follow-up re-hospitalization rate of individuals receiving services from peer support specialists (they called them "peer bridgers") was significantly less than the baseline hospitalization rate (i.e., the 2-year period prior to enrollment where no peer interaction occurred). That is, during the 2-year baseline period, individuals were hospitalized an average of 60% of the time; while enrolled in the program with peer specialists they were re-hospitalized only 19% of the time. That's an improvement of 41%.

In more recent data analysis conducted in 2008, examining the same program in New York, 176 inpatient clients consented to receive peer support services. After receiving peer support, initial review of this data revealed 125 of these individuals were not re-hospitalized in the state psychiatric center the following year. That means that 71% percent of the clients who received support from peer specialists were able to stay out of the hospital in 2009[9].

OptumHealth, a national behavioral health organization, utilized certified peer specialists to offer respite services instead of immediately sending individuals in crisis to the hospital. Using this new service, Pierce County, Washington was able to reduce involuntary hospitalizations by 32%, leading to a savings of 1.99 million dollars in one year.
In another OptumHealth example, certified peer specialists are being used as health coaches with late life populations. The average individual being served was 71 years of age. At the time of being assigned a health coach 100% of the clients had been hospitalized, but only 3.4% were hospitalized after working with a coach. The Average length of stay prior to having a coach was 6 days. The average length of stay after getting a coach was just 2.3 days[10].

[6] Dennis Smith, Department of Health and Human Services, Centers for Medicare and Medicaid Services, Letter to State Medicaid Directors, August, 2007
[7] Report by New York Association of Psychiatric Rehabilitation Services, Inc. titled "The Cost Effectiveness of Using Peers as Providers" by Sue Bergeson, Optimum Health, 2011.
[8] Fricks, Larry, PowerPoint presentation at the SAMSHA National Mental Health Block Grant and Data Conference, 2007.
[9] http://www.nyaprs.org/peer-services/peer-bridger/
[10] http://www.nyaprs.org/e-news-bulletins/2011/003285.cfm

Recovery Innovations in Arizona offers peer advocacy services. This hospital-based peer support is provided everyday with a focus on developing recovery plans and recovery-oriented discharge plans including strategies to reduce readmission. Since the peer support specialist staff have been working in the two hospital facilities, there has been, according to hospital administration, a reduction of 36% in the use of seclusion and a 48% reduction in the use of restraint, and a 56% reduction in hospital readmission rates[11].

Increase in Adherence and other Positive Outcomes

There is a wide range of research that shows using trained peers leads to improvement in psychiatric symptoms and decreased hospitalization. In studies of persons dually diagnosed with serious mental illness and substance abuse, peer led interventions were found to significantly reduce substance abuse, mental illness symptoms, and crisis[12].

Other research has revealed that individuals who participate in peer delivered services build larger social support networks[13]. Peer delivered service participants showed greater levels of independence, empowerment and self-esteem. Over 60% indicated increased development of social supports[14]. Involvement in peer support results in creation of a social network, change in role from helpee to helper, sharing of coping behaviors, presence of role model and existence of a meaningful group structure[15].
Additional benefits that peer specialists provide include:

- Serving as role a model to the individuals they work with,
- Voicing and brokering the needs of consumers,
- Serving as important sources of information,
- Serving as a powerful source of motivation,
- Helping others while helping themselves,
- Serving as mentors to others, helping them to better understand paths to recovery,
- Assisting clients in navigating often-fragmented service systems,
- Interpreting and in some cases mediating between staff and clients,
- Challenging unacknowledged stigma and bias toward clients,
- Augmenting the services of overburdened mental health systems, thereby increasing access to services[16].

The Importance of Acceptance and Support for Peer Support Specialists
Peer support specialists do not work in a vacuum. There is a growing recognition that the effectiveness of peer support does not rest solely on an individual peer provider but is enhanced when the peer support specialist is supported and valued within his/her organization and the service delivery system. Support for PSS was a topic of concern at several of Colorado's stakeholder meetings.

[11] http://www.recoveryinnovations.org/pdf/RIA%20Programs%20and%20Outcomes.pdf
[12] Magura, S., Laudet, A., Mahmood, D., Rosenblum, A. and Knight, E. (2002). Adherence to medication regimens and participation in dual-focus self-help groups. Psychiatric Services, 53(3), 310-316
[13] Carpinello, S. E., Knight, E. L., & Janis, L. (1991). A qualitative study of the perceptions of the meaning of self-help, self-help group processes and outcomes, Albany, NY: New York State Office of Mental Health.
[14] Van Tosh, L., & Del Vecchio, P. (2000). Consumer-operated self-help programs: A technical report. Rockville, MD:U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
[15] Carpinello, S., Knight, E., and Janis, L. (1992). A study of the meaning of self-help, self-help processes, and outcomes. Paper presented at the Third Annual Conference on State Mental Health Agency Services Research, Arlington, VA: NASMHPD Research Institute, Inc., 37-44.
[16] Chinman, M., Hamilton, A., Butler,B., Knight, E., Murray, S., Young, A. (2008). *Mental Health Consumer Providers: A Guide for Clinical Staff.*

Anthony O. Ahmed, PhD, Assistant Professor of Psychiatry, Georgia Regents University[17], identified a number of key strategies that contribute to the proliferation of peer services. The strategies are not just about training for PSS but also focus on system changes of education for other staff and championing peer support. The strategies include:

- Identifying and valuing the unique contributions of peers
- Providing compensation commensurate with background and experience
- Providing education and training for PSS to enhance their skills
- Senior level staff become champions of peer staff
- Providing training and education for non-peer staff
- Dissemination of success stories.

Important to note are the many misconceptions of peer specialists and recovery coaches that should not be seen as detrimental to their effectiveness. While every case should be treated differently, these common myths should never be assumed:

- Cannot work full time, either because of disability insurance or the responsibility
- Cannot fulfill the same roles as providers who are not consumers
- Will relapse – this is possible for any employee and only furthers the stigma you are trying to fight against
- They are too fragile to handle the stress of the job
- Cannot handle the administrative demands of the job
- Given they are not professionals, they will invariably cause harm to clients that the other staff members will have to undo

The International Association of Peer Supporters (iNAPS), then the National Association of Peer Specialists, conducted a survey in order to determine tasks performed by peer specialists, their satisfaction, compensation levels and their outlooks for the future. The survey was distributed on iNAPS website, at a national conference for peer specialists, and direct email to iNAPS members. A total of 173 surveys were completed, representing 35 states[18].

Results:

Average Hourly Wage	Average Number of Weekly Hours	Average Years on the Job	Average Number of Peers Served Weekly	Percent with Specific Job Training	Percent Interested in More Job Training
$12.13	29.5	2.8	16.7	82.7%	81.5%

There were many people who listed that they would be interested in additional training in Wellness Recovery Action Planning, public speaking, peer rights and legal issues, leadership, computer skills, boundaries and ethics, anti-stigma, trauma, diagnoses, benefits, motivational interviewing, conflict resolution and supervision skills.

[17] Ahmed, A. (2012). The Peer Provider Collaboration as a Platform for Research and Service Delivery. Presentation at the Georgia Mental Health Consumer Network's 2012 Summer Conference in St. Simon's Island, Georgia.

[18] http://www.papeersupportcoalition.org/peer/PeerSpecialistCompensationandSatisfactionSurveyReport.pdf
Peer Specialist Compensation and Satisfaction Survey Report (2007), National Association of Peer Specialists

Other interesting statistics found from this study include 73.5% of people responded that they work as peer specialists because they enjoy "helping others", 60.7% of people reported being mostly satisfied with their work and 48.9% reported that they worked part-time – respondents were asked to select what the reasons were that prevented them from working full time (as seen in the chart below):

Mental Health	Benefit Loss	Administrators/Managers	Demand for Service	Physical Health	Low Wages	Other
17%	36.7%	9.5%	4.1%	11.6%	6.8%	13.6%

43.8% reported that they expected to stay in this field of work forever.

INAPS concluded that; Looking at hourly wages, number of weekly hours worked and longevity, there is reason for concern about the level of integration of peer specialists in the mental health treatment workforce. The occupation is low paying with little apparent opportunity to create a meaningful career path that will enable peer specialists to move beyond dependence on entitlements, particularly Social Security disability benefits. The majority (66.3%) of peer specialists work for non-profit organizations with almost 20 percent working for government agencies. If wages, work hours and working conditions are to change significantly, these employers must be the focal points for worker advocacy.

SECTION SIX

Proposal for a Colorado Certification Model

The Peer and Family Workgroup, mentioned in Section One, has spent the past two years reviewing other states' models for credentialing and working with Colorado's Office of Behavioral Health identify a process for Colorado. The following is the proposed model based on resources available in the state and input and feedback from the statewide peer workforce initiative convenings.

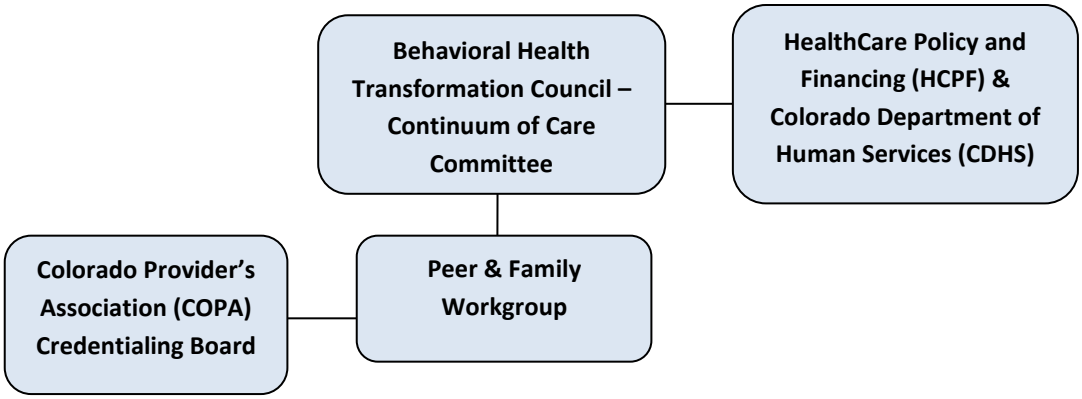
A statewide credentialing board is formed through a voting process and made up of peer support providers and supervisors that are representative of the state's peer community, in addition to other invested stakeholders (i.e., Office of Member/Client and Family Affairs Directors, advocacy organizations & treatment provider representatives, as well as individuals from CDHS and HCPF). The board assists in the revisions, updates and approval of core competencies set forth by HealthCare Policy and Financing (HCPF).

The credentialing board will establish criterion for vetting individuals applying for Colorado Peer or Family Support Certification. Individuals who have received training to work as a peer support professional will complete an application that is submitted to the credentialing board for review. An exam and training that meets the core competencies is a prerequisite for application, individuals who have received training prior to the creation of the core competencies will be grandfathered-in assuming they demonstrate their comprehension of the skills and can pass the exam.

The credentialing board will be made up of 12 individuals that will serve two year terms. The designations will go as follows:

- One representative from the Office of Behavioral Health at CDHS
- One representative from the Department of HealthCare Policy and Financing
- Two representatives from the Family Advocacy community (one peer and one advocate)
- Two representatives from the Recovery Coach community (one peer and one advocate)
- Two representatives from the Peer Support Specialist community (one peer and one advocate)
- One representative from Colorado Behavioral Healthcare Council
- Two representatives from two different Behavioral Healthcare Organizations (at least one OCFA/OMFA)
- One representative from SAMHSA's Regional Office

Proposed Oversight Model for Peer Credentialing in Colorado



For continuity, the Credentialing Board will adopt one definition for both peer specialists and recovery coaches statewide as set forth by the Substance Abuse and Mental Health Services Administration (SAMHSA) and modified in 2012 by the iNAPS Colorado Chapter;

Peer specialists and Recovery Coaches perform a set of non-clinical, peer-based activities that engage, educate and support an individual successfully to make life changes necessary to recovery from mental health conditions and/or substance use disorder conditions. The activities that comprise this service are education, advocacy and coaching. A key element contributing to the value of this relationship is that peer specialists and recovery coaches appropriately highlight their personal lived experience of recovery that is shared among them. Peer specialists and recovery coaches act as a recovery and empowerment catalyst; guiding the recovery process and supporting the individual's goals and decisions[19]*.*

This definition will set the tone for organizational definitions throughout the state regardless of the titles used (e.g., peer specialist, peer mentor, recovery coach). Furthermore, the board will develop and implement a universal job description, handbook and guide for employers to disseminate and help unify peer programs throughout Colorado

[19] http://www.samhsa.gov/grants/blockgrant/Self_Directed_Care_Service_Definition_05-09-2011.pdf

Conclusions

From the Convenings

It was clear from the statewide convenings that legitimacy and acceptance of the peer profession is an issue for peers and providers alike. Peer support specialists, recovery coaches and family systems navigators/family advocates want the recognition that they are playing an important role in service delivery and providers want to know that the individuals they hire are well trained and able to do the job.

Legitimacy can best be solved by a credentialing process, 36 states have already embraced some form of training and certification process. Colorado is poised to implement a statewide peer and family support certification process. It will require advocacy and support from our state government, provider organizations, advocates and peer providers themselves to ensure the process is a success.

At the time of the finalization of this paper the Peer and Family Workgroup chose not to include the voices of peers and family members statewide in the credentialing decision, outside of the individuals listed earlier in this paper. The Network fundamentally disagrees with this decision and has expressed this to fellow advocates and stakeholders.

Additionally, efforts within Colorado and throughout the country already underway will become a factor in the credentialing for peers long term. National organizations representing peer support professionals intend to develop certification standards and credentialing in the near future. The Substance Abuse and Mental Health Services Administration (SAMHSA) is involved in a global approach to legitimizing peers as are organizations and state entities (Colorado Department of Public Health and Environment) who represent other “lay providers” (i.e., community health care workers, patient navigators).

From the perspective of the Colorado Mental Wellness Network and the individuals it represents there will be several options available for working in the field as a peer provider, whether it be within the public or private system.

From the Peer and Family Workgroup

The Peer and Family Workgroup voted in December to endorse the Colorado Provider Association (COPA) to move forward with a credentialing process through the International Certification & Reciprocity Consortium (IC&RC) in 2015. The organization has agreed to collaborate with members of the community to ensure that individuals with lived experience from both the substance use and mental health communities are involved, as well as provider organizations and state representatives.

Efforts are already underway to develop the credentialing advisory board under COPA and a grandfathering process is planned for 2015 so that peers who are already working in the field can apply for certification. Other specifics are yet to be determined, Matt Sundeen is the contact at COPA and can be reached at: matt@coprovidersassociation.org (.)

In conclusion, the most important aspect of this emerging workforce, peer providers themselves, have had at least one opportunity to share their true vision for the future. The recommendations outlined in this document should be considered when developing and implementing peer programming. Working together with transparency and inclusion will ensure the successful future of Colorado’s behavioral healthcare system.